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FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN6201	A. BUILDING _____ B. WING _____	02/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TENNESSEE HEALTH CARE	465 ISBILL RD MADISONVILLE, TN 37354

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N 000	Initial Comments An annual Licensure survey was conducted at East TN Health Care on February 6, 2012, through February 21, 2012. The facility was cited a Type A penalty for failure to follow a systematic process of assessing for appropriate use of the restraint and failure to reduce or eliminate side rail restraints for residents (#41, #60, and #18), failure to reduce or eliminate a side rail restraint after multiple falls from the bed with full side rails in use for resident (#41), and failure to identify the risk for side rail entrapment for resident (#18, and #60). The facility's failure placed residents #41, #60, and #18 in an environment that was detrimental to his/her health, safety, and welfare.	N 000	**N 401 1200-8-6-.04(1)** **Administration** **Requirement:** The administrator shall assure the provision of appropriate fiscal resources and personnel required to meet the needs of the residents. **Corrective Action Plan:** 1. As of 3/5/12, the facility is providing a safe environment through the comprehensive assessment of each resident including #41, 60, 18, 55, 94, 57, and 83 to meet the resident's needs and maintaining their optimal physical, mental and psychosocial well being. 2. (a) The Administrator with the assistance of the Nursing Administration Staff has reviewed the needs of all patients to ensure that safety measures are maintained. New equipment or supplies was ordered and implemented as needed to ensure the resident's optimal physical, mental and psychosocial well being is maintained.	
N 401	1200-8-6-.04(1) Administration (1) The nursing home shall have a full-time (working at least 32 hours per week) administrator licensed in Tennessee, who shall not function as the director of nursing. Any change of administrators shall be reported in writing to the department within fifteen (15) days. The administrator shall designate in writing an individual to act in his/her absence in order to provide the nursing home with administrative direction at all times. The administrator shall assure the provision of appropriate fiscal resources and personnel required to meet the needs of the residents. This Rule is not met as evidenced by: Based on medical record review, facility policy review, review of training seminar information, review of Guidance for Industry and FDA (Federal	N 401		

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N 401	Continued From page 1 Drug Administration) staff, dated 2006, observation, and interview, the facility failed to be administered in a manner to ensure seven residents (#41, #60, #18, #55, #94, #57, #83) were provided a safe enviornment of fourty-three residents reviewed. The facility's failure to provide a system to assess for the use of siderails, to reduce or eliminate full siderails to prevent falls and to reduce the risk of entrapment placed residents #41, #60, and #18 and any resident who used full side rails, in an environment which was detrimental to their health, safety and welfare. The findings included: Interview with the Director of Nursing (DON) on February 6, 2012, at 7:50 p.m., confirmed the faciity became aware of the potential for entrapment with the use of the current full length siderails and the use siderails as restraints while attending a training seminar the past summer "sometime prior to August 1, 2011." Interview with the Nursing Home Administrator (NHA) and the DON on February 7, 2012, at 9:50 a.m., confirmed the Corporate Office some time prior to August 1, 2011, had instructed the facility Administration to reduce the full siderails if possible. Continued interview confirmed the DON after return from the training seminar had made the Interdiscplinary Team aware and maintenance had started ordering siderails, entrapment proof bars and half siderails to replace them as needed. Interview with the NHA and review of a training seminar information form on February 17, 2012, at 3:20 p.m., confirmed the NHA had attended	N 401	**N 401 1200-8-6-.04(1) cont...** 3.(a) The Administrative Staff (Administrator, Director of Nursing, Maintenance Director and the Maintenance Asisstant) was in-serviced on 2/7/12, 2/13/12, and/or 2/21/12 by the Regional Nurse Consultant and/or Regional Director of Operations on side rail standards, assessment prior to and ongoing use of restraints/side rails, resident assessments, revision of care plans, how to measure side rails and the recommended zone measurements per FDA Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006, investigation of occurrences (falls), implementation of interventions to reduce the occurrence of incidents, monitoring effectiveness of interventions, referring residents for assessment by therapist for appropriate interventions, job responsibilities, abuse protocol (list not all inclusive: investigation, reporting, screening of employees, employee training).	

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N 401	Continued From page 2 the same training seminar the DON had previously attended related to siderails as a restraint and as an entrapment risk on October 25, 2011. Continued interview and review of the training seminar information form confirmed the training seminar included training and information on use of siderails as restraints and the use of certain types of siderails with entrapment risks	N 401	**N 401 1200-8-6-.04(1) cont...** 4. (a) The Administrator or Director of Nursing will conduct random audits weekly through facility walking rounds, review of the 24 hour report, care plans, Nurse Aide Communication Sheets, Evaluation for the Use of Side Rails, and Nurse Event notes to ensure that the delivery of care is provided to meet the resident's goal. The facility will provide equipment as needed in order to achieve the resident's highest functional status. The Administrator will report findings in the morning Quality Assurance Meeting (Monday-Friday) and review with the Medical Director in the quarterly QA to assist residents in meeting resident's meeting and as needed. (b) The Regional Nurse Consultant will conduct random audits of facility documentation and random patient / staff interviews to ensure facility is maintaining compliance	
N 424	1200-8-6-.04(15) Administration (15) Each nursing home shall adopt safety policies for the protection of residents from accident and injury. This Rule is not met as evidenced by: Based on medical record review, facility policy review, Guidance for Industry and FDA (Food and Drug Administration) Staff, observation, and interview, the facility failed to reduce or eliminate a siderail restraint after multiple falls from the bed with full side rails in use, for one resident (#41) of two residents reviewed, failed to identify the risk for side rail entrapment for two residents (#18, #60) of two residents of twenty-three residents reviewed for siderails, failed to assure safety devices were on and properly operating for two residents (#57, #94) two of two residents of ten residents reviewed for accidents, and failed to supervise to prevent falls for one resident (#55) of forty-three residents reviewed. The facility's failure placed residents #41, #60 and #18, in an environment which was detrimental to their health, safety and welfare. The facility's failure to provide supervision to prevent falls resulted in harm for resident #55.	N 424		

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N 424	Continued From page 3 The findings included: Resident #41 was admitted to the facility on September 23, 2011, and readmitted to the facility on October 24, 2012, with diagnoses including Alzheimer's Disease, Deep Vein Thrombosis, and Hypertension. Medical record review of the Current Nurse Aide Communication Worksheet revealed "...interventions put in place...don't leave in DR (dining room) unattended when up in W/C (wheelchair)...check alarm during daily routine for placement...monitor resident while in room and up in chair..." Medical record review of a Fall Risk Assessment dated September 23, 2011, revealed "...moderate risk for falls...equipment issues (types of equipment used)...include side rails..." Medical record review of the Admission Care Plan dated September 23, 2011, revealed "...Frog (falls reduction our goal) program...call light in reach..." Medical record review of the September 2011, Physician Recapitulation Orders revealed "...pressure alarm release applied to bed D/T (due to) decrease of safety awareness check every shift for placement rt (related to) function...Lovenox (anticoagulant) 40 mg (milligrams) subcutaneous every day..." Medical record review of the Physical Therapy Plan of Treatment dated SOC (start of care) dated September 25, 2011, revealed "...risk for falls can be combative..."	N 424	**N 401 1200-8-6-.04(1) cont...** with facility, State and Federal Policies/Regulations. (c) The Regional Director of Operations will conduct random audits during visits to ensure the facility is being operated following Facility, State, and Federal Policies/Regulations and maintaining the resident's optimal physical, mental and psychosocial well being.	3/5/12

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N 424	Continued From page 4 Medical record review of a Nurse's Event Note dated September 27, 2011, at 6:15 a.m., revealed "...found resident lying in bathroom floor...c/o (complains of) R (right) hip...L (left) hip pain..." Review of the facility investigation report dated September 27, 2011, completed by the DON revealed "...side rails up..." Medical record review of a Physician's Order dated September 27, 2011, revealed "...pressure alarm release applied to bed D/T decrease of safety awareness check every shift for placement rt (related to) function..." Medical record review of the Interdisciplinary Team (IDT-DON, Assistance Director of Nursing (ADON) , Therapy, Clinical Manager, Dietary, Social Services, Activities, Maintenance Director, etc.) - Initial Care Meeting dated September 28, 2011, revealed "...Hx (history) of falls x (times)1 past 3 months..." Medical record review of a Nurse's Event Note dated September 30, 2011, at 8:15 p.m., revealed "...found sitting in floor...bed rails were up...alarm in place...not sounding..." Interview with Licensed Practical Nurse (LPN) #1on February 14, 2012, at 7:50 a.m., in the Nurse's Station, confirmed LPN #1 was on duty on September 30, 2011, when the resident fell. Continued interview revealed the resident was in the bed prior to the fall the side rails were in the up position, the alarm did not sound, and the resident was placed back in the bed with the side rails in the up position. Medical record review of the Resident Assessment documentation notes reference date	N 424	**N 424 1200-8-6-.04(15)** **Administration:** The facility shall adopt safety policies for the protection of residents from accident and injury. **Corrective Action Plan:** 1. As of 3/5/12, the facility is providing a safe environment through the comprehensive assessment of each resident to meet the resident's needs and maintaining their optimal physical, mental and psychosocial well being. (a) Resident #41's plan of care was reviewed and revised, after assessing his fall potential risks, his side rails were removed. His care plan reflects the new interventions. (b) Resident # 60 The side rails that were in place during the survey were immediately changed to full anti-entrapment rails (prior to the exit of the surveyors) on 2/6/12 by the Maintenance Director. The	

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N 424	Continued From page 5 September 30, 2011, revealed "...bed rail restraint used in bed...climbs out of bed over rails...currently...both side rails up..." Medical record review of a Nurse's Event Note dated October 4, 2011, at 4:30 a.m., revealed "...pt (patient) on his knees at side of bed holding on to (raised) bed rails...pulled self to standing position...both alarms appeared to be turned off...abrasion x (times) 3...". Continued review revealed no new interventions and no intervention to remove the siderails. Telephone interview with LPN #3, on February 14, 2012, at 6:45 a.m., confirmed the resident was found in the floor on October 4, 2011, at 4:30 a.m., and the side rails were in the up position. Medical record review of the Nurse's Readmission Assessment dated October 24, 2011, revealed the resident required assist with all activities of daily living, incontinent of bowel and bladder, combative at times, unable to make decisions, and history of falls. Medical record review of the Fall Risk assessment dated October 24, 2011, revealed "...high risk for falls...equipment issues...include side rails..." Medical record review of a Physician's Order dated November 16, 2011, revealed "...D/C (discontinue) pressure bed alarm and W/C (wheel chair) alarm..." Medical record review of a physician's order dated November 23, 2011, revealed "...Coumadin (anticoagulant) 5 mg every day at 1600..." Medical record review of a Nurse's Event Note	N 424	measurements for the bed zones were obtained by the Maintenance Director on 2/6/12 using a standard tape measure. The Side Rail Assessment and Informed Consent Form (one form) was later completed by the Staffing Coordinator on 2/6/12 for the use of side rails with a reduction from full side rails to ½ side rails after receiving a physician's order for the use of ½ rails by the Staffing Coordinator (after the exit of the surveyors for the evening) that were changed out per the Maintenance Director. The bed zone measurements were obtained by the Maintenance Director on 2/6/12. A Pre-Restraint Assessment was completed on 2/21/12 by the Staffing Coordinator that indicated side rails being used as a restraint and assisting the resident with position changes. An Evaluation for the use of Side Rails was completed on 2/23/12 by	

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N 424	Continued From page 6 dated November 23, 2011, at 6:00 a.m., revealed "...found on the floor beside bed resident had climbed over the side rails...skin tear...abrasion..." Review of the fall investigation report dated November 23, 2011, completed by the DON revealed "...climbed over the side rails...". Continued review revealed no new interventions and no intervention to remove the siderails. Telephone interview with LPN #2, on February 13, 2012 at 3:19 p.m., confirmed LPN #2 was on duty when the resident was found on the floor and climbed over the side rails on November 23, 2011, at 6:00 a.m., and the alarm did not sound. Interview with Certified Nurse Aide (CNA) #1 on February 13, 2012, at 3:25 p.m., in the Nurse's Station, confirmed CNA #1 was on duty and assigned to resident #41, on November 23, 2011, at 6:00 a.m., when the resident climbed over the bed rails, was found in the floor, and the bed alarm did not sound. Medical record review of the Nurse's Event Notes dated October 31, 2011, revealed the resident was left up in the bedside chair unattended and had a fall. Continued review revealed from November 5, 2011, through February 6, 2012, the resident was left unattended in the resident's room, in the wheel chair and the resident experienced a total of five falls. Medical record review of the Nurse's Event Notes dated December 10, 2011, and January 13, 2012, revealed the resident was left unattended in the Dining Room and the resident fell on both dates. Medical record review of the comprehensive Care Plan as reviewed on December 22, 2011,	N 424	**N 424 1200-8-6-.04(15) cont...** the Staffing Coordinator with a reduction of side rails from ½ side rails to ¼ side rail in combination with a low bed. The bed/side rails were changed out by the Maintenance Director; measurements were obtained on 2/23/12. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/26/12. (c) Resident #18 The side rails that were in place during the survey were immediately changed to full anti-entrapment rails on 2/6/12 by the Maintenance Director after receiving a physician's order. The measurements for the bed zones were obtained by the Maintenance Director on 2/6/12 using a standard tape. The Staffing Coordinator wrote a narrative note in the nurses notes on 2/6/12 describing the resident with limited functional status using the side rails as a restraint. A Physical Restraint Assessment was	

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N 424	Continued From page 7 revealed "...confusion alteration in thought process...at risk for falls...bed rails up to define edge of bed and for mobility...low bed...bed alarm...monitor alarm...do not leave resident unattended while up in chair...resident out of bed on awakening...at risk for bleeding secondary to anticoagulation therapy..." Medical record review of the January 2012, Physician's Recapitulation Orders revealed "...low bed with mats..." Medical record review of the February 2012, Physician's Recapitulation Orders revealed "...low bed..." Observation on February 8, 2012, at 5:28 p.m., in the resident's room, revealed full side rails on the bed and the bed rail on the left side of bed in the up position. Observation on February 13, 2012, at 7:42 a.m., revealed the resident lying on the bed with the clip alarm attached to the pillow case. Interview with the DON on February 13, 2012, at 7:42 a.m., confirmed the clip alarm was attached to the pillow case and if the resident attempted to exit the bed the clip alarm would not alarm. The DON states, "I'm just going to D/C (discontinue) it." Observation with the DON on February 14, 2012, at 1:53 p.m., revealed the resident lying on the bed, the bed was not in the lowest position, and the clip alarm was underneath the pillow and not attached to the resident. Interview with the resident's Medical Doctor (MD) on February 14, 2012, at 2:40 p.m., in the Nurse's	N 424	**N 424 1200-8-6-.04(15) cont...** updated on 2/6/12 by the Staffing Coordinator for the use of side rails. A Side Rail Assessment and Informed Consent was signed by the family on 2/13/12. On 2/20/12 the MDS Coordinator completed an Evaluation for use of Side Rails with a reduction in side rails from full (anti-entrapment) to ½ rails, the physician was notified and order was obtained for ½ rails. The measurements for the bed zones were obtained by the Maintenance Director on 2/20/12. On 2/23/12 the resident was evaluated again for side rail reduction by the Staffing Coordinator, the resident's side rails was eliminated and the resident was placed on a low bed with mats. The Physical Restraint Assessment was completed on 2/28/12 by the Staffing Coordinator for the elimination of side rails and the use of a low bed with mats after receiving a physician's order. The care plan was audited by the Nursing	

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N 424	Continued From page 8 Station, revealed the resident "100 percent absolute risk for bleeding, and head injuries with bleed, due to multiple falls and on anticoagulation therapy." Further interview confirmed the MD was unsure how many falls the resident had experienced, was unaware the facility was using full side rails daily as a restraint, and stated "I do not agree with side rails at all times, and feel the facility should have had the resident in a low bed to keep the risk factors down." Interview with the DON on February 14, 2012, at 12:53 p.m., in the small dining room, confirmed the resident was admitted with risk for falls, had experienced fourteen falls from September 25, 2011 through February 7, 2012, interventions were put in place not to leave the resident unattended in room/dining room, clip alarm while in bed/chair check for placement and function every shift, get out of bed when awakes, and lay down for rest periods. Continued interview confirmed the facility used full side rails daily to prevent the resident from transferring unassisted, the resident exited the bed with the full side rails in the up position four times, and the resident was placed back in the bed with full side rails in the up position until February 6, 2012, when the full side rails were removed from the resident's bed. Further interview confirmed the resident was left unattended in a bedside chair and wheel chair six times and the clip alarm failed to sound four times. Continued interview confirmed there was no documentation the clip alarm was checked for function and placement every shift. Observation with the DON on February 14, 2012, at 1:53 p.m., in the resident's room, revealed the resident lying on the bed, the bed not in the lowest position, and the clip alarm underneath the pillow not attached to the resident.	N 424	**N 424 1200-8-6-.04(15) cont…** Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/29/12. (d) Resident # 57 A telephone order was received from the resident's physician for the use of ½ side rails on 2/10/12. The resident was assessed on 2/20/12 using the Evaluation for use of Side Rails indicating the use of ½ side rails by the Staffing Coordinator. A Pre-Restraint Assessment was completed on 2/21/12 by the Director of Nursing that indicated side rails are used as a restraint. On 2/24/12 another Evaluation for the use of Side Rail was completed by the Staffing Coordinator indicating the elimination of ½ side rails (no side rails are in place at this time). As of 2/24/12 the resident's current interventions include: the locking of wheel chair prior to transfer, offer rest periods, assist to the bathroom	

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N 424	Continued From page 9 Resident #18 was admitted to the facility on June 15, 2009, with diagnosis including Osteoporosis, Dementia, Affective Psychosis, Depression and Hypertension. Review of the Resident Assessments dated August 20, 2011 and November 14, 2011, revealed the resident required extensive assistance with all ADLs (Activity of Daily Living), required the use of a non-self release seatbelt when in a WC (wheelchair) due to poor safety awareness, and no siderail assessment had been identified. Medical record review of the resident's care plan dated February 6, 2012, revealed : Transfer in and out of bed using 2 person assist ...non self release soft belt when up in wheelchair due to poor safety awareness...Make sure bedrails are up X2 (both sides) when in bed to assist with mobility..." Observation with the Maintenance Director, on February 6, 2012, at 6:55 p.m., revealed the resident in bed, with the head of the bed elevated to approximately forty-five degrees. Continued observation revealed full siderails bilaterally, but raised only on the left side of the bed, leaving a gap between the bottom of the siderail and top of the mattress on the left side. Continued observation revealed the Maintenance Director measured a gap between the bottom of the siderail and the top of the mattress at six and one-half inches, with the head of the bed elevated revealing potential entrapment risk. Review of Guidance for Industry and FDA (Food and Drug Administration) Staff dated March 10, 2006, revealed "...Hospital Bed System	N 424	**N 424 1200-8-6-.04(15) cont...** during rounds and as needed, bed in lowest position, a chair sensor pad. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/29/12. The resident's care plan was reviewed by the Director of Nursing on 3/7/12 and evaluated for fall prevention strategies and deemed the intervention for constant supervision during toileting was inappropriate. After review of current interventions on 3/7/12 by the Director of Nursing and further investigation of the incident (with intervention not to leave unattended) it was determined that the intervention was implemented before a full root cause analysis was conducted (the intervention was removed as of	

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N 424	Continued From page 10 Dimensional and Assessment Guidance to Reduce Entrapment...evaluating the dimensional limits of the gaps in hospital beds is one component of an overall assessment and mitigation strategy...most vulnerable to entrapment are elderly patients... especially those who are frail, confused...incontinence, pain or who get out of bed and walk unsafely without assistance...one component of a bed safety program includes a comprehensive plan for patient assessment...FDA recommends ...a risk benefit analysis to reduce entrapment...FDA using a head breadth dimension 4 3/4 inches as the basis for its dimensional recommendations...FDA recommends space be small enough to prevent neck entrapment...head entrapment under the rail less than 4 3/4 inches...in some positions the potential for entrapment exist when the deck is articulated... movement of the bed deck is known as articulation...we recommend that patient assessment procedures be used to assess the risk of entrapment when clinical care is provided in an articulated position...FDA have defined zones...could potentially become trapped...Zone...2(head entrapment under the rail)...accounting for 80% of entrapment events reported...some rails have high and low locking position...requires testing at both positions...Zone 2 test...if the space becomes larger as the bed moves find the bed position that creates the largest space...perform the test with the bed in the position where the space is the largest...common mistakes...not articulating the bed enough to create the largest possible gap..." Interview with the DON on February 15, 2012 at 3:12 p.m., in the small dining room, confirmed, the faciltiy has no formal assessment tool for use of side rails or what type of siderail to put in place,	N 424	**N 424 1200-8-6-.04(15) cont...** 2/24/12 interventions above). The resident remains on the FROG program, participates in restorative with ambulation "walk to dine program", further monitoring and interventions will continue to prevent falls. (e) Resident #94 The facility staff provides supervision through routine rounds (minimum of every 2 hours), during care delivery, activities, and meals. The chair sensor pad was discontinued on 3/5/12 by the Director of Nursing after reviewing current interventions. After placing the resident in the correct wheel chair with anti-lock brakes on 2/6/12 the resident was identified not to be at risk for falls of a similar incident (wheel chair rolling back). The resident utilizes the wheel chair to push himself into a standing position; the anti-lock brakes prevent the chair from rolling providing the	

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	TN6201	A. BUILDING _____ B. WING _____	02/21/2012

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EAST TENNESSEE HEALTH CARE	465 ISBILL RD MADISONVILLE, TN 37354

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N 424	Continued From page 11 and no policy and procedure/guidelines for side rail usage. Resident #60 was readmitted to the facility on September 26, 2011, with diagnoses including Pneumonia with Aspiration, Alzheimer's Disease, Congestive Heart Failure, Weakness, and GERD (Gastroesophageal Reflux Disease) Medical record review of the Pre-Restraint Assessment dated December 11, 2010, revealed "...disoriented at times...attempts to transfer/ambulate without assistance...restraint is not recommended..." Medical record review revealed no documentation of a pre-restraint assessment after December 11, 2010, and no restraint reduction assessment Medical record review of the assessment dated December 5, 2011, revealed "...required extensive assistance with bed mobility...moderately impaired for decision making...feeds self after set up and no restraints in use..." Medical record review of the Care Plan dated December 5, 2011, revealed "...res (resident) requires bedrails so...may assist with...repositioning...cannot transfer or ambulate without assist at this time...resident must be sitting upright for all meals..." Medical record review of a Fall Risk Assessment dated December 7, 2011, revealed "...risk scale moderate...equipment issues...side rails..." Medical record review of the February 2012 Physician Recapitulation Orders revealed "...restraint orders...side rails up while in bed to	N 424	**N 424 1200-8-6-.04(15) cont...** resident with stability. An identifier with the resident's name was attached to the wheel chair on 2/29/12. The resident's care plan was reviewed and updated by the Director of Nursing on 2/29/12 to reflect the resident's current status. After review of current interventions on 3/7/12 by the Director of Nursing and further investigation of the incident (with intervention not to leave unattended was not identified as an appropriate intervention to prevent falls). The resident remains on the FROG program and does not require constant supervision, further monitoring and interventions will continue to prevent falls. (f) **Resident # 55** was assessed using a Pre-Restraint Assessment (used due to the use of side rails as restraint) was completed on 2/6/12 by the MDS Coordinator indicating	

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	TN6201	A. BUILDING _____ B. WING _____	02/21/2012

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N 424	Continued From page 12 facilitate bed mobility..." Observation on February 6, 2012, at 2:12 p.m., in the resident's room, revealed the resident lying on the bed with bilateral full side rails in the up position, head of bed elevated approximately forty-five degrees and a gap between the top of the mattress and bottom of the side rails. Observation on February 6, 2012, at 4:50 p.m., in the resident's room, revealed the resident lying on the bed with the full side rails in the up position and the head of bed elevated approximately forty-five degrees, and a gap between the top of the mattress and the bottom of the siderails. Observation and interview with the resident on February 6, 2012, at 5:15 p.m., in the resident's room, confirmed the resident uses the side rails for bed mobility, is aware of the call light, and states, "I tried to get up once, I bumped my noggin (head) at times on the rails, that is why that stuff is on them, and my hand slips sometimes when I try to raise up." Continued observation revealed the upper part of the side rails closest to the resident's head is covered with a gray foam material and a gap is visible between the bottom of the side rail and the top of the mattress with the head of the bed elevated to approximately forty-five degrees. Observation and interview with the DON and the Maintenance Director in the resident's room, on February 6, 2012, at 5:35 p.m., revealed the resident's head of the bed elevated to forty five degrees. Continued observation and interview revealed the Maintenance Director measured the full side rails from the top of the mattress to the bottom of the full side rail in the middle of the bed	N 424	**N 424 1200-8-6-.04(15) cont...** that a restraint (3/4 side rail and geri chair) was recommended due to cognition impaired, physical limitations, and history of falls. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/6/12. No further assessments could be completed due to the resident expiring on 2/16/12. 2. The Nursing Administration Staff reviewed all residents using side rails and the resident's individual fall risk assessment scores to identify those that may be at risk for injury. A comprehensive assessment was completed; interventions were modified as needed and placed on the individuals care plan. The Administration Team developed a Side Rail Assessment Policy with the involvement of the Medical Director on 2/28/12 to include the utilization of the Evaluation for the use of Side Rail Assessment.	

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	TN6201	A. BUILDING _____ B. WING _____	02/21/2012

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N 424	Continued From page 13 and measured the gap to be seven and one fourth inch. Further interview with the DON in the resident's room confirmed the resident is usually up but has been sick today, has been in the bed most of the day, and the resident moves self in bed using the side rails. Interview with the Maintenance Director, on February 6, 2012, at 6:38 p.m., in the small dining room, confirmed the side rails were identified as needing to be replaced by his "boss" (Regional Maintenance Director). Continued interview with the Maintenance Director confirmed the Maintenence Director was aware of a tool that is available to measure the gap between the side rails and the mattress but the tool was never available to the facility and the Maintenance Director had no documentation of beds in the facility being measured by the tool. Interview with LPN #1 in the Nurses Station on February 14, 2012, at 7:42 a.m., confirmed the resident's head of bed is adjusted as far as possible while eating and is left elevated for at least forty-five minutes to one hour due to aspiration and choking and the resident ate lunch in bed on February 6, 2012. Interview with Restorative Aide #1 on February 16, 2012, at 8:50 a.m., in the Nurse's Station, confirmed the CNA lowers side rails, the resident can lift up from the lying position, put feet on floor, can hold to the wheel chair and attempts to self-transfer, self transfers from wheel chair to bed side chair, and if the rail on the bed and is in the down position can self-transfer chair to bed. Interview with the DON on February 14, 2012, at 8:05 a.m., in the Nurse's Station, confirmed the resident is capable of exiting the bed, and had not	N 424	**N 424 1200-8-6-.04(15) cont...** 3.(a)The administrative staff (Administrator, Director of Nursing, Maintenance Director and the Maintenance Asisstant was in-serviced on 2/7/12, 2/13/12, and/or 2/21/12 by the Regional Nurse Consultant and/or Regional Director of Operations on side rail standards, assessment prior to and ongoing use of restraints/side rails, resident assessments, revision of care plans, how to measure side rails and the recommended zone measurements per FDA Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006, investigation of occurrences (falls), implementation of interventions to reduce the occurrence of incidents, monitoring effectiveness of interventions, referring residents for assessment by therapist for appropriate interventions, job responsibilities, abuse protocol (list not all inclusive: investigation, reporting, screening of employees, employee training).	

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	TN6201	A. BUILDING _____ B. WING _____	02/21/2012

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N 424	Continued From page 14 been assessed for a least restrictive device prior to February 6, 2012. Continued interview confirmed a seven and one fourth inch gap did exist from the bottom of the side rail and top of the mattress when the head of the bed is elevated. Further interview confirmed the resident's head of bed is elevated during meals and left elevated after meals due to risk of aspiration. Continued interview with the DON confirmed the facility did not consider the seven and one half inch gap between the side rails and mattress an entrapment risk. Interview at 9:12 a.m. on February 21, 2012 by telephone with the resident's Physician confirmed no physician's order had been given for side rails, the physician was not aware of the facility using side rails for the resident, and the risk associated with side rail usage. Resident #57 was admitted to the facility on November 1, 2011, with diagnoses including Alzheimer's Disease, Hypertension, and Senile Dementia. Medical record review of the Fall Risk Assessment dated January 3, 2012, revealed the resident was a high risk for falls and had experienced three falls in the past 90 days. Medical record review of the Resident assessment dated January 4, 2012, revealed "...severe cognitive impairment...independent for locomotion on and off unit...side rails used daily for restraints..." Medical record review of a Nurse's Event Note dated January 31, 2012, revealed "...found resident lying in floor...alarm not sounding..."	N 424	4. (a) The Administrator or Director of Nursing will conduct random audits weekly through facility walking rounds, review of the 24 hour report, care plans, Nurse Aide Communication Sheets, Evaluation for the Use of Side Rails, and Nurse Event notes to ensure the appropriate procedures and policies are being followed. The Administrator will report findings in the morning Quality Assurance Meeting (Monday-Friday) and review with the Medical Director in the quarterly QA meeting and as needed. (b) The Regional Nurse Consultant will conduct random audits of facility documentation and random patient / staff interviews to ensure facility is maintaining compliance with facility, State and Federal Policies/Regulations. (c) The Regional Director of Operations will conduct random audits during visits to ensure the facility is being operated following Facility, State, and Federal Policies/Regulations and maintaining the resident's optimal physical, mental and psychosocial well being. **Completion Date: 3/5/12**	

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	TN6201	A. BUILDING _____ B. WING _____	02/21/2012

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N 424	Continued From page 15 Observation on February 17, 2012, at 9:10 a.m., in the resident bathroom, revealed Licensed Practical Nurse (LPN) #4 assisted the resident on the commode, instructed the resident to pull the string (call light) and left the resident unattended in the bathroom. Observation with the Nursing Home Administrator (NHA), on February 17, 2012, at 9:30 a.m., (twenty minutes later) in the resident's room, revealed the resident sitting in the wheel chair with feet elevated on the bed, and the clip alarm not in place. Interview with the Director of Nursing on February 17, 2012, at 9:35 a.m., in the Nurse's Station, confirmed the clip alarm was not functioning at the time of the fall on January 31, 2012, the clip alarm is to be in place and the resident was not to be left unattended in the bathroom. Resident #94 was admitted to the facility on November 25, 2011, with diagnoses including Dementia, Chronic Kidney Disease Stage III, Osteoporosis/Renal Bone Disease, and Hypertension. Medical record review of the Resident Assessment dated December 2, 2011, revealed the resident required extensive assistance of two for transfers, and limited assist of two persons with ambulation. Medical record review Care Plan dated December 5, 2011, revealed "...At risk for falls due to gait disturbance related to weakness and prior falls at home. Resident needs limited to extensive assist with transfers, assistance with walking and toileting at this time..."	N 424		

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EAST TENNESSEE HEALTH CARE	465 ISBILL RD MADISONVILLE, TN 37354

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N 424	Continued From page 16 Medical record review of a Fall Risk Assessment dated December 11, 2011, revealed the resident was at moderate risk for falls. Medical record review of a Nurse's Event Note dated December 11, 2011, at 6:00 p.m., revealed "...This nurse heard a resident call out that someone had fallen. I immediately went to hallway and this resident was laying in floor by...w/c (wheelchair). Resident stated...was trying to get up and push...w/c to...room. Resident able to move all extremities WNL (within normal limits). Resident assisted back into w/c et into room. no complaints voiced..." Review of facility investigation revealed the resident had forgotten to lock the brakes before getting up from the wheelchair and anti-roll back brakes were to be applied to the wheelchair. Medical record review of the Care Plan updated on December 12, 2011, revealed place anti-roll back brakes to the wheelchair, and on December 20, 2011, a bed and chair alarm was applied. Medical record review of a Nurses's Event Note dated December 18, 2011, at 7:10 p.m., revealed "...CNA (Certified Nursing Assistant #7) came to this charge nurse stated resident had fallen. Upon further investigation CNA found resident on trash can, went to get assistance, when returned resident was on floor. CNA verbally/corrective action taken...Head to toe assessment performed at 7:10 p.m. no apparent injury noted. Full ROM (range of motion) in all extremities; denies any pain or discomfort..." Medical record review of the Care Plan updated on December 20, 2011, revealed a bed and chair alarm was applied.	N 424		

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	TN6201	A. BUILDING _____ B. WING _____	02/21/2012

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EAST TENNESSEE HEALTH CARE	465 ISBILL RD MADISONVILLE, TN 37354

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N 424	Continued From page 17 Telephone interview on February 13, 2012, at 10:50 a.m., with LPN #2 confirmed when the resident fell on December 18, 2011, the resident was left unattended on the trash can at the time of the resident's fall, and the CNA had been counseled related to leaving the resident unattended. Medical record review of a Nurses's Event Note dated February 3, 2012, at 7:00 p.m., revealed "...Nurse heard pt (patient) screaming 'help' and observed pt on the floor, fell on buttocks, no apparent injury. Pt was able to voice needs and move all extremities without difficulty..." Interview on February 16, 2012, at 10:20 a.m., with the DON, outside the DON's office confirmed the anti-roll back brakes were not applied to the resident's wheelchair at the time of the resident's fall on February 3, 2012. Continued interview revealed it was unknown if the resident had been using the correct wheelchair at the time of the fall. Observation and interview on February 13, 2012, at 8:45 a.m., with Registered Nurse (RN) #1 revealed the resident sitting in a wheelchair in the resident's room with anti-roll back brakes applied to the wheelchair, and confirmed the chair alarm was not attached to the resident. Resident #55 was admitted to the facility on July 9, 2008 with diagnoses including Brain Syndrome with Presenile Brain Disease, Hypertension, and Osteoarthrosis. Medical record review of the fall risk assessment dated December 20, 2011, revealed the resident was at moderate risk for falls. Medical record review of a Nurse's Event Note	N 424		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 424	Continued From page 18 dated January 22, 2012 revealed "...went in res (resident) room and found laying in bathroom floor...res stated "I thought I could put myself on pot...immediate steps implemented to prevent recurrence: placed res in w/c (wheelchair) et (and) placed res in lobby where staff could monitor...comment/action taken bring to nurses station for closer monitoring..." Medical record review of a Nurse's Event Note dated January 23, 2012, revealed "...resident (up) in w/c in room. PTA #1(Physical Therapist Assistant) observed resident sit up in chair and slid to floor-laying on r (right) side (no s/s (signs/symptoms) injury)...immediate steps implemented to prevent recurrence: keep in hallway in sight of staff-take to room if putting to bed comment/action taken bring to nurse's station for closer monitoring...don't leave in rm (room) unattended when up in w/c..." Medical record review of a Nurse's Event Note dated January 24, 2012 revealed "... PTA #1 across hall noticed resident standing in room-unable to reach (resident)-resident fell on floor next to wall-laying on (left) hip...immediate steps implemented to prevent recurrence: sent to ER (emergency room)-will re-evaluate use of restraint upon return..." Medical record review of a physician's order dated January 24, 2012, revealed, "...Send to ER...(left) hip pain..." Medical record review of a Nurse's Note dated January 24, 2012, revealed "...Resident returned to facility via ambulance/stretcher from (named hospital)...knee immobilizer...Fx (fractured) (left) patella (and) tibia..."	N 424		

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	TN6201	A. BUILDING _____ B. WING _____	02/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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N 424	Continued From page 19 Interview on February 13, 2012, at 9:10 a.m., in the small dining room, with PTA #1 (witness to the fall) confirmed PTA #1 had observed the resident to stand from the w/c in the resident's room and fall. Interview on February 13, 2012, at 9:15 a.m., with the DON, in the small dining room, confirmed the intervention to keep the resident in the hall in sight of staff when up in the wheelchair had not been followed on the January 23, and January 24, 2012, falls, resulting in a fractured patella and tibia.	N 424	**N 601 1200-8-6-.06(1)(a)** **Basic Services** **Requirement:** The nursing home must ensure that there is an effective, facility-wide performance improvement program to evaluate resident care and performance of the organization.	
N 601	1200-8-6-.06(1)(a) Basic Services (1) Performance Improvement. (a) The nursing home must ensure that there is an effective, facility-wide performance improvement program to evaluate resident care and performance of the organization. This Rule is not met as evidenced by: Based on medical record review, observation, facility policy review and interview, the facility failed to ensure the Quality Assurance Committee developed and implemented plans to address resident safety related to the use of full side rails, likely entrapment and falls for three residents (#41, #18, #60) of forty-three residents reviewed. The facility's failure to develop and implement plans to address resident safety related to the use of full side rails, likely entrapment and falls is likely to cause serious harm, injury, or death. The facility's failure placed residents #41, #18, and #60 in an environment which was detrimental to their health, safety and welfare.	N 601	**Corrective Action Plan:** 1. A special session of the QA Committee was held on 2/23/12 by the Administrator. The committee reviewed the results of the annual survey as expressed during the survey exit with the review of the immediate specifics and implementation of the plan of correction to remove the immediate jeopardy. A Side Rail Policy was developed by the QA Committee and the Medical Director with implementation on 2/28/12 for the assessment of all residents for the use of side rails, the review of MDS's and Care Plans to ensure	

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	TN6201	A. BUILDING _____ B. WING _____	02/21/2012

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N 601	Continued From page 20 The findings included: Interview with the Nursing Home Administrator (NHA) and the Regional Director of Operations on February 21, 2012, at 9:15 a.m., in the NHA office, confirmed falls had been an ongoing Quality Assurance Program. Further interview with the NHA and Regional Director of Operations related to side rails as a restraint, and side rail entrapment confirmed the Quality Assurance (QA) Committee had not utilized data from Nurse's Event Notes or information obtained at a seminar the NHA had attended in October, 2011 in an effort to identify potential areas of improvement or implemented a plan to address areas of concern.	N 601	current interventions and accuracy; the monitoring by the Administrative staff to ensure systems are followed and revised as needed; and to ensure staff training is provided as needed for processes/systems implemented. The QA Committee will review audit results related to the annual survey (list not all inclusive: restraints, side rail assessment, side rail measurements. Pre-Restraint Assessment, Physical Restraint Assessment, MDS's, Care Plans) discussing and modifying systems as needed to maintain compliance.	
N 615	1200-8-6-.06(2)(d)3. Basic Services (2) Physician Services. (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall: 3. Review reports of all accidents or unusual incidents occurring on the premises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rule is not met as evidenced by: Based on medical record review, facility policy review, observation and interview the Medical Director failed to provide oversight and participate in the development of policies and procedures to ensure resident safety and ensure that residents	N 615	2. All residents have the potential to be affected. 3. The QA Committee received in-service training by the Administrator and the Regional Nurse Consultant on 2/21/12, 2/22/12, and 2/23/12. The in-service covered but was not limited to: facility QA Policies and Procedures; Daily QA morning meetings; Monthly QA (Leadership team, Customer Service, Patient Care and Service); and Quarterly QA	

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	TN6201	A. BUILDING _____ B. WING _____	02/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAST TENNESSEE HEALTH CARE	465 ISBILL RD MADISONVILLE, TN 37354

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N 601	Continued From page 20 The findings included: Interview with the Nursing Home Administrator (NHA) and the Regional Director of Operations on February 21, 2012, at 9:15 a.m., in the NHA office, confirmed falls had been an ongoing Quality Assurance Program. Further interview with the NHA and Regional Director of Operations related to side rails as a restraint, and side rail entrapment confirmed the Quality Assurance (QA) Committee had not utilized data from Nurse's Event Notes or information obtained at a seminar the NHA had attended in October, 2011 in an effort to identify potential areas of improvement or implemented a plan to address areas of concern.	N 601	(goal setting, brainstorming, root cause analysis, etc.) The QA Committee will address concerns identified during the above meetings as needed, implementing guidelines, modifications with the assistance of the Medical Director to resolve reduce or eliminate concerns identified. The team will review alerts from agencies such as, but not limited to: CMS, THCA, and Q-Source to ensure appropriate measures are taken to obtain the goals associated with agency recommendations. Information discussed in the QA Committee will be disbursed to appropriate department personnel to improve patient care and services by a QA representative through training and educational sessions.	
N 615	1200-8-6-.06(2)(d)3. Basic Services (2) Physician Services. (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall: 3. Review reports of all accidents or unusual incidents occurring on the premises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rule is not met as evidenced by: Based on medical record review, facility policy review, observation and interview the Medical Director failed to provide oversight and participate in the development of policies and procedures to ensure resident safety and ensure that residents	N 615		

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	TN6201	A. BUILDING _____ B. WING _____	02/21/2012

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N 601	Continued From page 20 The findings included: Interview with the Nursing Home Administrator (NHA) and the Regional Director of Operations on February 21, 2012, at 9:15 a.m., in the NHA office, confirmed falls had been an ongoing Quality Assurance Program. Further interview with the NHA and Regional Director of Operations related to side rails as a restraint, and side rail entrapment confirmed the Quality Assurance (QA) Committee had not utilized data from Nurse's Event Notes or information obtained at a seminar the NHA had attended in October 2011 in an effort to identify potential areas of improvement or implemented a plan to address areas of concern.	N 601	4. The Administrator or Director of Nursing will review facility audits in morning QA meetings (Monday-Friday) and in the quarterly QA meeting to review areas that have improved and/or may need revisions. Action plans will be developed when a practice is determined to be deficient; the committee will monitor until compliance is met.	
N 615	1200-8-6-.06(2)(d)3. Basic Services (2) Physician Services. (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall: 3. Review reports of all accidents or unusual incidents occurring on the premises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rule is not met as evidenced by: Based on medical record review, facility policy review, observation and interview the Medical Director failed to provide oversight and participate in the development of policies and procedures to ensure resident safety and ensure that residents	N 615	**For Clarification Purposes:** The QA Committee consists of Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, MDS Coordinator(s), Bookkeeper, Food Service Supervisor, Social Worker, Maintenance Director and/or Maintenance Assistant, Activities Director. Direct caregivers (list not all inclusive: Licensed Nurses, CNA's, Restorative, Therapy) may be in attendance. **Completion Date: 3/5/12**	

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N 615	1200-8-6-.06(2)(d)3. Basic Services (2) Physician Services. (d) The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall: 3. Review reports of all accidents or unusual incidents occurring on the premises, identifying hazards to health and safety and recommending corrective action to the administrator; This Rule is not met as evidenced by: Based on medical record review, facility policy review, observation and interview the Medical Director failed to provide oversight and participate in the development of policies and procedures to ensure resident safety and ensure that residents	N 615	**N 615 1200-8-6-.06(2) (d) 3** **Basic Services-Physician Services** **Requirement:** The Medical Director shall be responsible for the medical care in the nursing home. The Medical Director shall: Review reports of all accidents or unusual incidents occurring on the premises, identifying hazards to health and safety and recommending corrective action to the administrator.	

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N 615	Continued From page 21 with restraints were properly assessed, managed, and restraint reduction or elimination was implemented where appropriate. The Medical Director's failure to collaborate with the facility to develop and implement policies and procedures related to resident safety placed residents #18, #41, and #60 in an environment which was detrimental to their health, safety and welfare. The findings included: Interview with the Medical Director (MD) on February 23, 2012 at 12:00 p.m., in the small dining room, revealed the MD was never called by the facility related to siderail issues; was unaware of the types of siderails used in the facility; and was unaware of potential entrapment with the siderails, or of falls due to siderail use. The MD stated reviewed all falls in the facility either on rounds or in QA (Quality Assurance), but was unaware of falls with injuries due to siderails or entrapment issues until last week. The MD further stated "...residents who exit the bed with siderails should be placed in low beds with fall mats and siderails should be discontinued." Continued interview revealed the MD attended some of the Quality Assurance Committee Meetings; is not involved in oversight and implementation of facility policies and procedures related to resident safety; and there was no system in place to identify and respond to these safety risks.	N 615	**N 615 1200-8-6-.06(2) (d) 3** **Basic Services-Physician Services** **Corrective Action Plan:** 1. The facility's Medical Director was made aware by the Administrator on 2/8/12 that the facility had received immediate jeopardy level deficiencies including F 490 for the manner in which the facility has been administrated. The Quality Assurance Committee met with the Medical Director on 2/23/12 to review deficiencies sited during the facility's recent annual survey, including those affecting resident #41, 18, and 60. The Administrator reviewed the literature on The FDA Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006. 2. All residents have the potential to be affected. The Administration Team developed a Side Rail Policy with the involvement of the Medical Director and implemented the policy	
N1208	1200-8-6-.12(1)(h) Resident Rights	N1208		

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N 615	Continued From page 21 with restraints were properly assessed, managed, and restraint reduction or elimination was implemented where appropriate. The Medical Director's failure to collaborate with the facility to develop and implement policies and procedures related to resident safety placed residents #18, #41, and #60 in an environment which was detrimental to their health, safety and welfare. The findings included: Interview with the Medical Director (MD) on February 16, 2012, at 12:00 p.m., in the small dining room, revealed the MD was never called by the facility related to siderail issues; was unaware of the types of siderails used in the facility; and was unaware of potential entrapment with the siderails, or of falls due to siderail use. The MD stated reviewed all falls in the facility either on rounds or in QA (Quality Assurance), but was unaware of falls with injuries due to siderails or entrapment issues until last week. The MD further stated "...residents who exit the bed with siderails should be placed in low beds with fall mats and siderails should be discontinued." Continued interview revealed the MD attended some of the Quality Assurance Committee Meetings; is not involved in oversight and implementation of facility policies and procedures related to resident safety; and there was no system in place to identify and respond to these safety risks.	N 615	on 2/28/12 to include the utilization of the Evaluation for the use of Side Rail Assessment. 3. The Administrator reviewed the functions and responsibilities with Medical Director on 2/23/12. The Administrator and/or Director of Nursing will notify the Medical Director as needed regarding issues that requires the revision and/or development of policies and procedures to meet the needs of resident and/or staff. 4. The Administrator will review the functions of the Medical Director through random audits and ensure that the development/revision of policies or systems is completed in the quarterly QA meeting and as needed. **Completion Date: 3/5/12**	
N1208	1200-8-6-.12(1)(h) Resident Rights	N1208		

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N1208	Continued From page 22 (1) The nursing home shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservation of dignity, individuality and, to the extent medically feasible, independence. Residents and their families or other representatives shall be fully informed and documentation shall be maintained in the resident's file of the following rights: (h) To be free from chemical and physical restraints; This Rule is not met as evidenced by: Based on Guidance for Industry and FDA (Food and Drug Administration March 2006) medical record review, facility policy review, observation, and interview, the facility failed to assess side rails as a restraint, failed to ensure siderails did not pose a risk for entrapment, and failed to reduce or eliminate side rail restraints for six residents (#41, #60, #18, #83, #55, #57) of forty three residents reviewed. The facility's failure to follow a systematic process of assessing for appropriate use of the restraint and failure to reduce or eliminate side rail restraints placed residents #41, #60, and #18 in an environment which was detrimental to their health safety and welfare.. The findings included: Review of the facility restraint policy dated August 2010, revealed,"...A restraint includes, but is not limited to any article, device, or garment that interferes with freedom of movement of the pt (patient) and that cannot be removed by the pt easily...Restraints must be used only after all	N1208		

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N1208	Continued From page 23 other measures have failed...there must be a link between restraint use & (and) how it benefits pt...All restraints must have: physicians order including the type of restraint, when & where the restraint should be used, the medical necessity of the restraint and restraint reduction attempts documented on the care plan. Resident #41 was admitted to the facility on September 23, 2011, and readmitted to the facility on October 24, 2011, with diagnoses including Alzheimer's Disease, Deep Vein Thrombosis and Hypertension. Medical record review of a Fall Risk Assessment dated September 23, 2011, revealed "...moderate risk for falls...include side rails..." Medical record review revealed no pre-restraint assessment for the use of the side rails and no physician order for the use of side rails. Medical record review of a Resident Care Area Assessment Documentation Notes reference date September 30, 2011, revealed "...bed rail restraint used in bed...climbs out of bed over rails...currently...both side rails up...". The full side rails were not care planned. Medical record review of a Nurse's Event Note dated September 27, 2011, at 6:15 a.m., revealed "...found resident lying in bathroom floor..." Medical record review of the facility investigation dated September 27, 2011, revealed "...side rails up...(intervention)...pressure release alarm applied to bed..." Medical record review of a Nurse's Event Note dated September 30, 2011, at 8:15 p.m., revealed "...found sitting in floor...bed	N1208	**N 1208 1200-8-6-.12(1) (h)** **Resident Rights** **Requirement:** The nursing home shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservation of dignity, individuality and, to the extent medically feasible, independence. Residents and their families or other representatives shall be fully informed and documentation shall be maintained in the resident's file of the following – physical restraints. **Corrective Action Plan:** 1. As of 3/5/12, the facility is providing a safe environment through the comprehensive assessment of each resident to meet the resident's needs and maintaining their optimal physical, mental and psychosocial well being.	

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N1208	Continued From page 24 rails were up...alarm in place...not sounding..." No new interventions for removal of full side rails were noted. Medical record review of the facility investigation dated September 30, 2011, revealed "...side rails up...(intervention)...in-serviced staff on how to properly operate bed alarm..." Medical record review of a Nurse's Event Note dated October 4, 2011, at 4:30 a.m., revealed "...pt (patient) on his knees at side of bed holding on to raised bed (bring up) rails...abrasion x (times) 3..." Medical record review of the Nurse's Readmission Assessment dated October 24, 2011, revealed "...required assist with all activities of daily living...incontinent of bowel and bladder...combative at times...unable to make decisions...and history of falls..." Medical record review of the Fall Risk assessment dated October 24, 2011, revealed "...high risk for falls...side rails..." Medical record review of a Physical Restraint Assessment dated October 24, 2011, revealed the resident had no signed consent for use of restraints, and "no restraint reduction or elimination is planned". Further medical record review revealed no prior physical restraint assessment and no physician order for the use of side rails. Medical record review of a Nurse's Event Note dated November 23, 2011, at 6:00 a.m., revealed "...found on the floor beside bed resident had climbed over the side rails...skin tear...abrasion..."	N1208	(a) Resident #41's plan of care was reviewed and revised, after assessing his fall potential risks, his side rails were removed. His care plan reflects the new interventions. (b) Resident # 60 The side rails that were in place during the survey were immediately changed to full anti-entrapment rails (prior to the exit of the surveyors) on 2/6/12 by the Maintenance Director. The Side Rail Assessment and Informed Consent Form (one form) was later completed by the Staffing Coordinator on 2/6/12 for the use of side rails with a reduction from full side rails to ½ side rails after receiving a physician's order for the use of ½ rails by the Staffing Coordinator (after the exit of the surveyors for the evening) that were changed out per the Maintenance Director. The Pre-Restraint Assessment was completed on 2/21/12 by the Staffing Coordinator that indicated side rails being used as a restraint and assisting the resident with position changes.	

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N1208	Continued From page 25 Review of the facility investigation report dated November 23, 2011, completed by the DON revealed "...climbed over the side rails... (intervention)...low bed with mats..." No new interventions for removal of the full side rails were noted. Medical record review of the Interdisciplinary Plan of Care reviewed on December 22, 2011, revealed "...confusion alteration in thought process...at risk for falls...bed rails up to define edge of bed and for mobility...low bed...bed alarm...monitor alarm...do not leave resident unattended while up in chair...at risk for bleeding secondary to anti coagulation therapy...". Medical record review of the January 2012, Physician's Recapitulation Orders revealed "...low bed with mats...", and no order for side rails. Medical record review of a resident assessment dated January 23, 2012, revealed the resident had severe cognitive impairment, required extensive assistance with bed mobility, transfers and ambulation, and full side rail restraints were used daily. Medical record review of the February 2012, Physician's Recapitulation Orders revealed "...low bed...", and no order for side rails. Observation on February 6, 2012, at 5:28 p.m., in the resident's room, revealed full side rails on the bed and the bed rail on the left side of bed in the up position. Interview with Licensed Practical Nurse (LPN) #1 on February 14, 2012, at 7:50 a.m., at the Nurse's Station, confirmed the resident was in the bed prior to the fall on September 30, 2011; the full	N1208	An Evaluation for the use of Side Rails was completed on 2/23/12 by the Staffing Coordinator with a reduction of side rails from ½ side rails to ¼ side rail in combination with a low bed. The bed/side rails were changed out by the Maintenance Director; measurements were obtained on 2/23/12. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/26/12. (c) Resident #18 The Staffing Coordinator wrote a narrative note in the nurses notes on 2/6/12 describing the resident with limited functional status using the side rails as a restraint. A Physical Restraint Assessment was updated on 2/6/12 by the Staffing Coordinator for the use of side rails. A Side Rail Assessment and Informed Consent	

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N1208	Continued From page 26 side rails were in the up position; the alarm did not sound, and the resident was placed back in the bed with the full side rails in the up position on September 30, 2011. Telephone interview with LPN #3, on February 14, 2012, at 6:45 a.m., confirmed the resident was found on the floor on October 4, 2011, at 4:30 a.m., and the full side rails were in the up position. Interview with the DON on February 14, 2012, at 12:53 p.m., in the small dining room, confirmed the facility used full bed rails daily to prevent the resident from transferring unassisted. Interview with the resident's Medical Doctor (MD) on February 14, 2012, at 2:40 p.m., in the Nurse's Station, revealed the resident, "A 100 percent absolute risk for bleeding, and head injuries with bleed, due to multiple falls and on anticoagulation therapy." Further interview confirmed the MD stated was unsure how many falls the resident has experienced, unaware the facility was using full side rails daily as a restraint, "I do not agree with side rails at all times, and feel the facility should have had the resident in a low bed to keep the risk factors down." Interview with DON on February 17, 2012, at 10:15 a.m., in the small dining room, confirmed the resident had exited the bed with the full side rails in the up position four times, there was no physician order for use of full side rails, the facility failed to complete a side rail/restraint assessment to determine the safety of the side rails and confirmed the facility continued to use full side rails as a restraint.	N1208	was signed by the family on 2/13/12. On 2/20/12 the MDS Coordinator completed an Evaluation for use of Side Rails with a reduction in side rails from full (anti-entrapment) to ½ rails, the physician was notified and order was obtained for ½ rails. The measurements for the bed zones were obtained by the Maintenance Director on 2/20/12. On 2/23/12 the resident was evaluated again for side rail reduction by the Staffing Coordinator, the resident's side rails was eliminated and the resident was placed on a low bed with mats. The Physical Restraint Assessment was completed on 2/28/12 by the Staffing Coordinator for the elimination of side rails and the use of a low bed with mats after receiving a physician's order. The care plan was audited by the Nursing Administration Staff to ensure that the plan of care had been updated to reflect the resident's current status on 2/29/12.	

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N1208	Continued From page 27 Resident #60 was readmitted to the facility on September 26, 2011, with diagnoses including Pneumonia with Aspiration, Alzheimer's Disease, Congestive Heart Failure, Weakness, and GERD (Gastroesophageal Reflux Disease) Medical record review of a resident assessment dated December 5, 2011, revealed "...required extensive assistance with bed mobility...moderately impaired for decision making...feeds self after set up...no restraints in use..." Medical record review of the Interdisciplinary Plan of Care dated December 5, 2011, revealed "...res (resident) requires bedrails so...may assist with...repositioning...cannot transfer or ambulate without assist at this time...resident must be sitting upright for all meals..." Medical record review of a Fall Risk Assessment dated December 7, 2011, revealed "...risk scale moderate...equipment issues side rails..." Medical record review of the Pre-Restraint Assessment dated December 11, 2010, revealed "...disoriented at times...attempts to transfer/ambulate without assistance...restraint is not recommended..." Medical record review of the February 2012 Physician Recapitulation Orders revealed "...restraint orders...side rails up while in bed to facilitate bed mobility..." Observation on February 6, 2012, at 2:12 p.m., in the resident's room, revealed the resident lying on the bed with bilateral full side rails in the up position, head of bed elevated approximately forty-five degrees and a gap between the top of	N1208	2. The Nursing Administration Staff reviewed all residents using side rails, assessing and coding the resident's assessment correctly. Residents using side rails as a restraint were identified and care planned accordingly. A comprehensive assessment was completed; interventions were modified as needed and placed on the individuals care plan. The Administration Team developed a Side Rail Policy with the involvement of the Medical Director with implementation on 2/28/12 to include the utilization of the Evaluation for the use of Side Rail Assessment.	

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EAST TENNESSEE HEALTH CARE	465 ISBILL RD MADISONVILLE, TN 37354

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N1208	Continued From page 28 the mattress and the bottom of the side rails. Observation on February 6, 2012, at 4:50 p.m., in the resident's room, revealed the resident lying on the bed with the full side rails in the up position, the head of bed elevated approximately forty-five degrees and a gap between the top of the mattress and bottom of the side rails. Observation and interview with DON and Maintenance Director in the resident's room, on February 6, 2012, at 5:35 p.m., revealed the resident's head of the bed elevated to forty five degrees; the Maintenance Director measured the full side rails from the top of the mattress to the bottom of the full side rail in the middle of the bed and measured the gap to be seven and one fourth inches. Review of Guidance for Industry and FDA (Food and Drug Administration) Staff dated March 10, 2006, revealed "...Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment...evaluating the dimensional limits of the gaps in hospital beds is one component of an overall assessment and mitigation strategy...most vulnerable to entrapment are elderly patients... especially those who are frail, confused...incontinence, pain or who get out of bed and walk unsafely without assistance...one component of a bed safety program includes a comprehensive plan for patient assessment...FDA recommends ...a risk benefit analysis to reduce entrapment...FDA using a head breadth dimension 4 3/4 inches as the basis for its dimensional recommendations...FDA recommends space be small enough to prevent neck entrapment...head entrapment under the rail less than 4 3/4 inches...in some positions the potential for	N1208	3.(a)The administrative staff (Administrator, Director of Nursing, Maintenance Director and the Maintenance Asisstant was in-serviced on 2/7/12, 2/13/12, and/or 2/21/12 by the Regional Nurse Consultant and/or Regional Director of Operations on side rail standards, assessment prior to and ongoing use of restraints/side rails, resident assessments, revision of care plans, how to measure side rails and the recommended zone measurements per FDA Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment dated March 10, 2006, investigation of occurrences (falls), implementation of interventions to reduce the occurrence of incidents, monitoring effectiveness of interventions, referring residents for assessment by therapist for appropriate interventions, job responsibilities, abuse protocol (list not all inclusive: investigation, reporting, screening of employees, employee training).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN6201	A. BUILDING _____ B. WING _____	02/21/2012

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EAST TENNESSEE HEALTH CARE	465 ISBILL RD MADISONVILLE, TN 37354

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N1208	Continued From page 29 entrapment exist when the deck is articulated... movement of the bed deck is known as articulation...we recommend that patient assessment procedures be used to assess the risk of entrapment when clinical care is provided in an articulated position...FDA have defined zones...could potentially become trapped...Zone...2(head entrapment under the rail)...accounting for 80% of entrapment events reported...some rails have high and low locking position...requires testing at both positions...Zone 2 test...if the space becomes larger as the bed moves find the bed position that creates the largest space...perform the test with the bed in the position where the space is the largest...common mistakes...not articulating the bed enough to create the largest possible gap..." Interview with Restorative Aid #2, on February 13, 2012, at 10:07 a.m., in the Nurse's Station, confirmed full side rails are up while the resident is in the bed, and was unsure why full side rails are in use for this resident. Interview with LPN #7 on February 13, 2012, at 10:59 a.m., in the small dining room, verified the resident "has always had the full side rails up while in bed". Interview with the DON, in the small dining room, on February 6, 2012, at 6:12 p.m., confirmed the most recent pre-restraining assessment was completed December 10, 2010, and confirmed the facility had not completed any restraint assessment after December 10, 2011. Interview with the Resident Assessment Coordinator on February 6, 2012, at 6:30 p.m., in the small dining room, confirmed the facility had no formal assessment for identifying the type of	N1208	(b) Facility staff was in-serviced were conducted on 2/6/12, 2/7/12, 2/8/12, 2/9/12, 2/13/12, 2/17/12, and 2/24/12 for facility staff by the Administrator, Maintenance Director and/or the Director of Nursing regarding but not limited to: the completion of Side Rail Assessment and Informed Consent, Evaluation for the use of Side Rails to be completed prior to the use of side rails, Pre-Restraint Assessment, Physical Restraint Assessment (when, on whom, why, and how the assessment is to be completed), the risk of entrapment associated with side rail use and how to obtain bed zone measurements per the FDA "best practice" standards. All staff was in serviced by the Administrator, Maintenance Director and/or the Director of Nursing regarding but not limited to: the completion of Side Rail Assessment and Informed Consent, Evaluation for the use of Side Rails to be completed prior to the use of side rails, Pre-Restraint Assessment, Physical Restraint	

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N1208	Continued From page 30 side rails to use; no specific order for type of side rails to be used; the facility is in process of changing the side rails to one-half side rails, "only able to order so many at a time due to financial reasons," and the concern with full side rails (used as a restraint) was identified back in the summer 2011. Interview with the DON on February 14, 2012, at 8:05 a.m., in the Nurse's Station, confirmed the resident was capable of exiting the bed, and an assessment to determine if use of the side rails was the least restrictive device had not been completed prior to February 6, 2012, after the Maintenance Director measured the seven and one-forth inch gap between the mattress and bottom of the side rail. Interview with the resident's Physician at 9:12 a.m., on February 21, 2012, by telephone, confirmed no physician's order had been given for use of side rails and "was not aware" of the facility using side rails for resident #60. Resident #18 was admitted to the facility on June 15, 2009, with diagnoses including Osteoporosis, Dementia, Affective Psychosis, Depression and Hypertension. Review of the resident's assessments dated August 20, 2011, and November 14, 2011, revealed the resident required extensive assistance with all ADLs (Activities of Daily Living) and required the use of a non-self release seatbelt when in WC (wheelchair) due to poor safety awareness. No other restraints were identified on the comprehensive quarterly assessments. Review of the resident's Care Plan dated	N1208	Assessment (when, on whom, why, and how the assessment is to be completed), the risk of entrapment associated with side rail use and how to obtain bed zone measurements per the FDA "best practice" standards on 2/29/12. 4. (a) The Director of Nursing or the Assistant Director of Nursing will conduct daily audits (Monday-Friday) for 90 days through facility walking rounds, review of the 24 hour report, care plans, Nurse Aide Communication Sheets, Evaluation for the Use of Side Rails, and Nurse Event notes to ensure the appropriate procedures and policies are being followed, then weekly audits times 90 days, then random audits as long as compliance is maintained. If at any time compliance is not met, daily audits will resume until compliance is obtained. The audit findings will be reviewed the morning Quality Assurance Meeting (Monday-Friday) and review with the Medical Director in the quarterly QA meeting and as needed. **Completion Date: 3/5/12**	

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	TN6201	A. BUILDING _____ B. WING _____	02/21/2012

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N1208	Continued From page 31 February 6, 2012, revealed, "...Transfer in and out of bed using 2 person assist...non self release soft belt when up in wheelchair due to poor safety awareness...Make sure bedrails are up X2 (both sides) when in bed to assist with mobility..." Medical record review revealed no assessment for siderail use. Continued medical record review of the January 2012 and February 2012 Physician's Recapitulation Orders revealed no order related to side rail use as a restraining device or as a mobility aide. Observation with the Maintenance Director, on February 6, 2012, at 6:55 p.m., revealed the resident in bed, with the head of the bed elevated to approximately forty-five degrees. Continued observation revealed full siderails bilaterally, but raised only on the left side of the bed, leaving a gap between the bottom of the siderail and mattress on the left side. Continued observation revealed the Maintenance Director measured a gap between the bottom of the siderail and the top of the mattress at six and one-half inches, with the head of the bed elevated revealing potential entrapment risk. Observation on February 13, 2012, at 3:30 p.m. revealed the resident resting in bed with half side rails up bilaterally at the resident's chest position extending to the knee position. Interview with the DON on February 6, 2012, at 6:10 p.m., in the small dining room, confirmed the side rails had not been assessed as a restraint. Resident #83 was re-admitted to the facility on March 16, 2011, with diagnoses including Alzheimer's Disease, Dementia, Osteoarthritis, Osteoporosis, Dysphagia w/ PEG tube	N1208		

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EAST TENNESSEE HEALTH CARE	465 ISBILL RD MADISONVILLE, TN 37354

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N1208	Continued From page 32 (percutaneous-esophageal-gastrostomy tube). Medical record review of the resident's assessments dated August 28, 2011, and January 5, 2012, revealed the resident required extensive assistance of one to two staff members for all activities of daily living. Continued MDS review revealed no restraints were used. Medical record review of a Care Plan dated March 21, 2011, and updated November 29, 2011, revealed "...Resident relies on staff for all transfers and mobility and could not prevent...self from falling...Bedrails up X 2." Continued care plan review revealed an added intervention dated October 5, 2011, stating "...ensure that side rails are locked in place before leaving the room." Further medical record review revealed no prerestraint assessment on admission or prior to the March 21, 2011, care plan for side rails., nor subsequent restraint assessments had been done to ensure the least restrictive device was in place. Medical record review of February 2012, Physicians Recapitulation Orders revealed "...may have SR (siderail) up X (times) 2 (bilateral side rails in the up position) for bed mobility. Continued review of physician's orders revealed a telephone order dated February 9, 2012, instructing: "DC (discontinue) full siderails, change to ¾ rails." Observations of the resident on February 6, 2012 at 9:07 a.m., February 7, 2012, at 8:23 a.m., and February 9, 2012 at 10:10 a.m., revealed the resident in the bed, alone in the room, with both full side rails locked in the "up" position.	N1208		

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N1208	Continued From page 33 Observations of the resident on February 14, 2012 at 10:10 a.m. and at 3:06 p.m. revealed the resident resting in bed with ¾ length side-rails extending from the top of the bed to knee position in the "up" position. Interview with the DON on February 14, 2012, at 1:20 p.m., in the nurse's station confirmed the side rail (full or 3/4 rails) would impede resident #83's freedom of movement from the bed; the side rails could not be lowered by the resident without staff assistance; and the use of side-rails was not assessed and treated as a restraint per facility policy. Resident #55 was admitted to the facility on July 9, 2008, with diagnoses including Psychotic Mood Disorder, Hx (History of) Falls, Dementia, and Osteoarthrosis. Review of the resident's assessment dated September 29, 2011, revealed restraint-bedrails used daily. Review of the Resident Care Area Assessment Documentation Notes dated December 15, 2011, revealed, "...Resident has used a non self release belt when up in wheelchair and bedrails on...bed long term...Will continue to monitor restraint to assure it is the least restrictive while still maintaining...safety..." Medical record review of the care plan dated December 15, 2011, revealed, "...Bedrails x 2 as gentle reminder to call for assist and for positioning..." Medical record review revealed no pre-restraint assessments or restraint reduction assessments had been completed.	N1208		

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N1208	Continued From page 34 Observation on February 6, 2012, at 1:50 p.m. revealed the resident lying on the bed with full siderails up bilaterally. Interview on February 15, 2012, at 10:40 a.m., with the Director of Nursing, in the small dining room confirmed no assessment for the use of the siderails had been completed prior to February 6, 2012. Resident #57 was admitted to the facility on November 11, 2010, with diagnoses including Alzheimer's Disease, Hypertension, and Senile Dementia. Medical record review of the resident's assessment dated January 4, 2012, revealed the resident had severe cognitive impairment, was independent for locomotion on and off unit, was placed in a chair that prevented the resident from rising and bed side rails were used daily as restraints. Medical record review of the Interdisciplinary Plan of Care dated January 5, 2012, revealed "...side rails up times two per resident request for mobility...do not leave resident on commode unassisted...chair alarm when OOB (out of bed)..." Medical record review of the January 2012, Physician Recapitulation Orders revealed no order for side rails. Medical record review of the February 2012, Physicain Recapitulation Orders revealed no order for side rails. Medical record review revealed no documentation	N1208		

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N1208	Continued From page 35 of a pre-restraint assessment or a restraint reduction assessment for the use of the chair and the side rails. Observation on February 6, 2012, at 4:02 p.m., in the resident's room, revealed the resident lying on the bed with one-half side rails in the up position on both sides of the bed. Interview with LPN #7 on February 7, 2012, at 11:17 a.m., in the break room, confirmed the resident has one-half side rails used daily, and the resident is capable of exiting the bed without assistance. Interview with the DON on February 8, 2012, at 8:42 a.m., in the Nurse's Station, confirmed facility had not completed a pre-restraint assessment or restraint reduction assessment. Interview with the Director of Nursing (DON) on February 6, 2012, at 6:12 p.m., in the small dining room, confirmed the DON was unaware of any residents attempting to exit the beds over the side rails; the facility performs side rail assessments on admission only; the facility has no formal assessment for use of side rails or what type to put in place; the facility has no policy and procedure/guidelines for side rails; and if a resident attempted to exit a bed with side rails in use they would be placed in a low bed. Further interview confirmed the DON attended a meeting this past year and was informed the facility needed to start reducing side rail use. In summary, the facility failed to provide a system to ensure residents were assessed prior to the use of side rails to determine medical necessity, and if the side rails were the appropriate least restrictive device to maintain the resident's safety.	N1208		

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N 615	Continued From page 21 with restraints were properly assessed, managed, and restraint reduction or elimination was implemented where appropriate. The Medical Director's failure to collaborate with the facility to develop and implement policies and procedures related to resident safety placed residents #18, #41, and #60 in an environment which was detrimental to their health, safety and welfare. The findings included: Interview with the Medical Director (MD) on February 16, 2012, at 12:00 p.m., in the small dining room, revealed the MD was never called by the facility related to siderail issues; was unaware of the types of siderails used in the facility; and was unaware of potential entrapment with the siderails, or of falls due to siderail use. The MD stated reviewed all falls in the facility either on rounds or in QA (Quality Assurance), but was unaware of falls with injuries due to siderails or entrapment issues until last week. The MD further stated "...residents who exit the bed with siderails should be placed in low beds with fall mats and siderails should be discontinued." Continued interview revealed the MD attended some of the Quality Assurance Committee Meetings; is not involved in oversight and implementation of facility policies and procedures related to resident safety; and there was no system in place to identify and respond to these safety risks.	N 615	on 2/28/12 to include the utilization of the Evaluation for the use of Side Rail Assessment. 3. The Administrator reviewed the functions and responsibilities with Medical Director on 2/23/12. The Administrator and/or Director of Nursing will notify the Medical Director as needed regarding issues that requires the revision and/or development of policies and procedures to meet the needs of resident and/or staff. 4. The Administrator will review the functions of the Medical Director through random audits and ensure that the development/revision of policies or systems is completed in the quarterly QA meeting and as needed. **Completion Date: 3/5/12**	
N1208	1200-8-6-.12(1)(h) Resident Rights	N1208		

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N 615	Continued From page 21 with restraints were properly assessed, managed, and restraint reduction or elimination was implemented where appropriate. The Medical Director's failure to collaborate with the facility to develop and implement policies and procedures related to resident safety placed residents #18, #41, and #60 in an environment which was detrimental to their health, safety and welfare. The findings included: Interview with the Medical Director (MD) on February 16, 2012, at 12:00 p.m., in the small dining room, revealed the MD was never called by the facility related to siderail issues; was unaware of the types of siderails used in the facility; and was unaware of potential entrapment with the siderails, or of falls due to siderail use. The MD stated reviewed all falls in the facility either on rounds or in QA (Quality Assurance), but was unaware of falls with injuries due to siderails or entrapment issues until last week. The MD further stated "...residents who exit the bed with siderails should be placed in low beds with fall mats and siderails should be discontinued." Continued interview revealed the MD attended some of the Quality Assurance Committee Meetings; is not involved in oversight and implementation of facility policies and procedures related to resident safety; and there was no system in place to identify and respond to these safety risks.	N 615	on 2/28/12 to include the utilization of the Evaluation for the use of Side Rail Assessment. 3. The Administrator reviewed the functions and responsibilities with Medical Director on 2/23/12. The Administrator and/or Director of Nursing will notify the Medical Director as needed regarding issues that requires the revision and/or development of policies and procedures to meet the needs of resident and/or staff. 4. The Administrator will review the functions of the Medical Director through random audits and ensure that the development/revision of policies or systems is completed in the quarterly QA meeting and as needed. **Completion Date: 3/5/12**	
N1208	1200-8-6-.12(1)(h) Resident Rights	N1208		